STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315248	A. BUILDING _____ B. WING _____	C 01/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANDOVER SUBACUTE AND REHAB II	99 MULFORD ROAD ANDOVER, NJ 07821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS C #: NJ 119359, NJ 119553 Census: 488 Sample Size: 3 Based on interviews and record review, as well as review of pertinent facility documents on 1/29/19 and 1/30/19, it was determined that the facility failed to prevent an elopement for 1 of 3 residents (Resident #1), reviewed for Elopement. On 1/21/19, at 3:30 a.m., Resident #1, who was [redacted]. The Licensed Practical Nurse (LPN #1) heard the [redacted] door alarm sound, however [redacted] did not respond to the alarm. Resident #1 was seen exiting (captured by the facility's surveillance camera) through the loading dock unalarmed door and climbed over the fence. The Resident was seen sitting on the ground, that was covered with ice at 4:45 a.m., by the Housekeeping Supervisor (HS) without a coat, socks, or shoes on. The Resident sustained abrasions to the back of the head, both feet, and injury to the forearms (injury not described in facility documentation). In addition, the staff could not obtain the Resident's body temperature. The Resident was sent to the [redacted] and was admitted for [redacted]. According to the [redacted] records, the weather was -4 degrees (negative four) Fahrenheit (F). In addition, the [redacted] records revealed that [redacted]	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315248	A. BUILDING _____ B. WING _____	C 01/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANDOVER SUBACUTE AND REHAB II	99 MULFORD ROAD ANDOVER, NJ 07821

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F 000	Continued From page 1 This created an Immediate Jeopardy (IJ) situation to the health, safety, and well-being for Resident #1 and the potential to affect eight other residents who were identified as an Elopement risk on the [redacted]. The IJ was identified on 1/29/19 at 2:44 p.m., for 1/21/19, involving Resident #1. The immediacy was removed on 1/29/19, when the facility submitted an acceptable Plan of Correction (POC) which included but was not limited to: LPN #1 was educated to respond to door alarms, policy on Wander Guard Placement and Elopement, security guards were stationed on the exit doors on the [redacted] Wing, and loading dock door until a new code was established on 2/1/19, by the alarm company.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: C #: NJ 119359, NJ 119553 Based on interviews and record review as well as review of pertinent facility documents on 1/29/19 and 1/30/19, it was determined that the facility failed to prevent an elopement for 1 of 3 residents	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315248	A. BUILDING _____ B. WING _____	C 01/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANDOVER SUBACUTE AND REHAB II	**99 MULFORD ROAD ANDOVER, NJ 07821**

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F 689	Continued From page 2 (Resident #1), reviewed for elopement risk. On 1/21/19, at 3:30 a.m., Resident #1, who was [redacted]. The Licensed Practical Nurse (LPN #1) heard the [redacted] door alarm sounded. However, she did not respond to the alarm. Resident #1 was seen exiting (captured by the facility's surveillance camera) through the loading dock unalarmed door and climbed over the fence. The Resident was seen sitting on the ground, that was covered with ice at 4:45 a.m., by the Housekeeping Supervisor (HS) without a coat, socks, or shoes on. The Resident sustained abrasions on the back of the head, both feet, and injury to the forearms. In addition, the staff could not obtain the Resident's body temperature. The Resident was sent to the [redacted] and was admitted for [redacted]. According to the [redacted] records, the weather was -4 (negative four) degrees Fahrenheit (F). In addition, the [redacted] records revealed that the Resident underwent [redacted] This created an Immediate Jeopardy (IJ) situation to the health, safety, and well-being for Resident #1 and the potential to affect eight other residents who were identified as an elopement risk on the [redacted]. The IJ was identified on 1/29/19 at 2:44 p.m., for 1/21/19, involving Resident #1. The immediacy was removed on 1/29/19, when the facility submitted an acceptable Plan of Correction (POC) which included but was not limited to: LPN #1 was educated to respond to door alarms,	F 689		

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	315248	A. BUILDING _____ B. WING _____	C 01/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANDOVER SUBACUTE AND REHAB II	**99 MULFORD ROAD ANDOVER, NJ 07821**

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F 689	Continued From page 3 policy on Wander Guard (electronic device that monitors resident movement and alerts staff) Placement and Elopement, security guards were stationed on the exit doors on the [redacted], and loading dock back door until a new code was established on 2/1/19, by the alarm company. This deficient practice is evidenced by the following: 1. According to "Admission Record" Resident #1 was admitted to the facility on [redacted], with diagnoses that included but were not limited: [redacted]. The Minimum Data Set (MDS), an assessment tool dated [redacted], showed that the Resident wa [redacted] The form "Elopement Risk Assessment" dated 1/19/19, revealed that Resident #1, was at risk for Elopement. A Care Plan (CP), initiated on 1/19/19, revealed that Resident #1 had eloped from previous facility's parking lot. Interventions included but were not limited to: Maintain environmental controls such as stairwell alarms, restricted window opening, elevator controls, keypad entry, to restricted areas, fenced perimeters, monitor whereabouts on all nursing rounds, and on 2/10/18, the Wander guard application was initiated.	F 689		

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	315248	A. BUILDING _____ B. WING _____	C 01/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANDOVER SUBACUTE AND REHAB II	**99 MULFORD ROAD ANDOVER, NJ 07821**

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F 689	Continued From page 4 The CP also showed: The Resident had eloped to the facility's lobby on 2/22/18, intervention included but was not limited to: Resident was redirected back to [redacted] Furthermore, the CP showed that on 1/21/19, the Resident was found outside the building, and the Resident was sent to an [redacted]. The form "Physician's Order Form" dated 1/2019, showed an order for Wander guard for safety. On 1/21/19, the Department of Health (DOH) received a Facility Reportable Event (FRE), involving Resident #1. The report revealed that on 1/21/19 at 4:45 a.m., Resident #1 was found sitting on the sidewalk, by the Housekeeping Supervisor (HS) as [redacted] entered the parking lot of the facility. The HS alerted the nursing staff and the security staff. The Resident was brought inside the facility and was noted to have abrasions on both knees and a small cut on the back of the head. Resident #1 was sent to an [redacted] for evaluation and treatment. The FRE also revealed that the Resident had a Wander guard in place prior to the event. During the tour on 1/29/19 at 10:00 a.m., the HS showed the surveyor the loading dock back door of the kitchen, where the Resident exited the facility. In addition, the HS showed the surveyor the fence that the Resident used to climb over, then the side walk where the Resident was found. During an interview with the HS on 1/29/19 at 10:00 a.m., the HS indicated that on 1/21/19 at approximately 4:45 a.m., [redacted] came to work and parked [redacted] car at the employee's parking lot. [redacted] recalled that the monitor inside [redacted] car read	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315248	A. BUILDING _____ B. WING _____	C 01/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANDOVER SUBACUTE AND REHAB II	99 MULFORD ROAD ANDOVER, NJ 07821

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F 689	Continued From page 5	F 689		

one-degree Fahrenheit and there was mix of snow and ice on the ground. The HS stated that when [redacted] came out of [redacted] car, [redacted] saw Resident #1 sitting on the sidewalk, awake, wearing a short sleeves shirt and pants, without a coat, socks, or slippers on. The HS immediately ran inside the building to get help and staff came out with [redacted] and brought the Resident back inside the building. The HS stated that the Resident went through the dietary door which led the Resident to the loading dock back door and climbed the fence to exit the facility. The HS explained that the Resident was very cold to touch and [redacted] was not sure how long the Resident was sitting on the ground that day (1/21/19). The HS revealed that [redacted] was not aware of any new intervention being implemented and/or inservice that was provided to [redacted] and the staff after the above incident.

During an interview with the Acting Maintenance Director (AMC) on 1/29/19 at 11:12 a.m, the AMC explained that [redacted] was aware of the incident on 1/21/19, involving Resident #1. The AMC stated that [redacted] immediately checked all exit doors on 1/21/19 at 7 a.m. The AMC revealed [redacted] findings when [redacted] checked all exit doors on 1/21/19 after the incident:
The [redacted] door did not fully latch, which could leave the door open. The AMC stated that [redacted] resolved this issue on that same date. The alarm for the loading dock door was deactivated. [redacted] revealed that some of the staff knew the code to deactivate the alarm and they used it occasionally. [redacted] also revealed that the loading dock door did not have a Wander guard alarm. The AMC further revealed that the code was not changed and staff could still use the same code to deactivate the alarm on the loading dock back door. The AMC further revealed that the camera

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315248	A. BUILDING _____ B. WING _____	C 01/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANDOVER SUBACUTE AND REHAB II	99 MULFORD ROAD ANDOVER, NJ 07821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 6	F 689		

surveillance showed that the Resident used the loading dock back door to exit the building and climbed over the fence and walked towards the sidewalk where the Resident was found by the HS. [redacted] went on to say that the distance between the loading dock back door and the sidewalk where the Resident was found was approximately 660 feet. The AMC stated that after the incident all exit doors were checked daily to ensure proper functioning. However, the code to deactivate the alarm to the loading dock back door was not changed. [redacted] further stated that [redacted] was not aware of any inservice provided such as Elopement and/or Wander guard policy after the incident.

During interview with day shift Nurse Supervisor (NS), on 1/29/2019 at 11:54 a.m., [redacted] confirmed that Resident #1 could walk independently and was at risk for Elopement. [redacted] stated that [redacted] was aware about Resident #1 being found outside the building. However, [redacted] had no information on how the Resident was able to get out of the building. [redacted] revealed that [redacted] was not aware of any in-services provided to the staff after the incident

During a telephone interview with LPN #1 on 1/29/2019 at 1:25 p.m. [redacted] confirmed that [redacted] was assigned to Resident #1 when the incident occurred on the night of 1/20/2019 to 1/21/2019 between the hours of 11 p.m. and 7 a.m. The LPN recalled that at approximately 3:30 a.m., the Resident woke up and was walking in the hallway of the [redacted] [redacted]e heard Certified Nurse Aide (CNA #1) direct the Resident to go back to bed. LPN #1 could not explain how the Resident ended up outside the building. However, [redacted] heard the [redacted] door alarm sound between 4:05 a.m. and 4:20 a.m. The LPN explained that [redacted] mentioned this to CNA #1 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315248	A. BUILDING _____ B. WING _____	C 01/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANDOVER SUBACUTE AND REHAB II	99 MULFORD ROAD ANDOVER, NJ 07821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 7	F 689		

the CNA responded by saying "it always beeping". The LPN revealed that [redacted] did not check the door when [redacted] heard the alarm because [redacted] was with another Resident who was very agitated at the time [redacted] heard the alarm sound. The LPN also revealed that [redacted] did not instruct any of the CNAs to check if there were missing residents on the [redacted] after the alarm sounded. LPN #1 stated that [redacted] became aware that Resident #1 was missing when [redacted] was called to the [redacted] to help attend to Resident #1 who was brought back inside the building. [redacted] was unable to recall what time that occurred. The LPN stated that [redacted] saw abrasions on Resident's head and legs. The Resident's hands were very cold. The LPN confirmed that the Resident was not wearing socks, shoes or jacket/coat on the night of 1/21/2019. LPN #1 revealed that prior to the Elopement [redacted] did not recall checking Resident #1's Wander guard placement that night (1/20/19 to 1/21/19). [redacted] went on to state that [redacted] did not receive in-services on Elopement/Wander guard policy after the incident. In addition, [redacted] further revealed that [redacted] worked another three shifts (1/21/19, 1/22/19, and 1/28/19) after the incident.

The facility's Investigation Report (IR) dated 1/21/2019, confirmed what was documented on the FRE. However, additional findings were documented:

Registered Nurse (RN #1) observed the Resident with an [redacted]

RN #2 was unable to obtain vital signs due to cold

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315248	A. BUILDING _____ B. WING _____	C 01/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANDOVER SUBACUTE AND REHAB II	**99 MULFORD ROAD ANDOVER, NJ 07821**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 8 extremities. Resident # 1 was transferred to an [redacted] Resident #1 between 3:51 a.m. and 3:55 a.m., exited the unit, unwitnessed. LPN #1 was with another resident who was highly agitated and combative and was unaware that Resident #1 had even left the unit. Attached with the IR, the statements from CNAs #1 and #2, who stated that they heard an alarm sounded, however, they were with another resident on 1/21/19. The Investigation Report concluded: Resident #1, [redacted], resides on a [redacted] The Maintenance determined that the door was found to be broken and thus prevented the alarm from sounding. Security camera was reviewed and showed that Resident #1 proceeded to exit through the kitchen loading dock back door, where the Resident climbed a seven feet fence. [redacted] walked the facility grounds, eventually sitting on the sidewalk where [redacted] was observed by the HS. This investigation revealed the following interventions were implemented to prevent the same incident from occurring: "The kitchen loading dock door was repaired, maintenance will do alarm checks daily and document in a log book ...the doors leading to the resident dining area will be closed daily at 8:30 p.m., the dual alarm system will be engaged. Maintenance will check the alarms daily and document in log book. All staff will be re-educated that it is critical to respond to door alarms immediately. When responding to the door alarm staff will identify the	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315248	A. BUILDING _____ B. WING _____	C 01/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANDOVER SUBACUTE AND REHAB II	99 MULFORD ROAD ANDOVER, NJ 07821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 9	F 689		

cause of the alarm. If unable to identify the cause they will notify the nurse on duty. A unit headcount will be conducted ...if warranted, the facility's elopement policy will be immediately instituted. A Security Officer will be assigned to the [redacted] area outside ...under no circumstances will the Security guard leave his/her post ...the facility will hire additional security personnel to monitor the perimeter of the property via the facility's camera system ..."

The interventions did not indicate that a code to deactivate the alarm on the loading dock back door was changed.

Attached with the IR, the form "In-Service Attendance Record" dated 1/22/19, regarding Alarm and Wander guard alarm that was provided to the CNAs. There was no facility wide in-service provided to other disciplines, including LPN#1. In addition, there was no facility wide in-service regarding the Elopement policy.

The surveyor conducted an interview with the LPN #2, the facility's In-Service Coordinator, on 1/30/19 at 12:04 p.m. [redacted] stated that prior to the incident, LPN #1 was inserviced on Wander guard and Elopement policy, which was incorporated under "Resident Safety, Falls & Restraints". [redacted] went on to state that after the incident involving Resident #1, the facility will add the "Door Alarm Policy" as one of the topics to be discussed during the General Orientation for new employees.

The form "General Orientation In-Service" signed by LPN #1 on 10/22/18, showed that the LPN received the following education but was limited to: Resident Safety, Falls and Restraints,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315248	A. BUILDING _____ B. WING _____	C 01/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANDOVER SUBACUTE AND REHAB II	99 MULFORD ROAD ANDOVER, NJ 07821

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F 689	Continued From page 10	F 689		

Documentation, and Dementia/ Alzheimer's Disease.

A review of the form "11-7 Wander guard List" showed a total list of eight residents (including Resident #1) who were using a Wander guard on [redacted]. This same form did not reflect that the Wander guard was checked for proper functioning weekly from January 1 to 20, 2019.

During an interview with the Quality Assurance (QA) CNA#2 on 1/30/19 at 12:47 p.m., she stated that the Wander guard alarm was being checked weekly on the night shift, however, the last time [redacted] checked the Wander guard was on the last week of December 2018. [redacted] explained that on those nights that [redacted] was scheduled to work to check the Wander guard for functioning, [redacted] was scheduled alone and did not have the chance to check all the residents with Wander guard on the list.

During a post survey a telephone interview with CNA #1 on 2/4/19 at 9:05 a.m., [redacted] confirmed that [redacted] was the assigned CNA for Resident #1 at 11 p.m. to 7 a.m., on 1/20/19 to 1/21/19. [redacted] recalled that [redacted] saw Resident #1 standing by door of the Resident's room on 1/21/19 at 3:30 a.m., and [redacted] encouraged the Resident to return to bed. Then CNA #1 proceeded to go to another room (which was 2 doors away from the Resident's room) to take care of another resident. [redacted] stated that while [redacted] was toileting another resident [redacted] heard a "beeping" sound, however, [redacted] did not respond because [redacted] could not leave the resident alone in the bathroom. [redacted] revealed that a "beeping" sound meant that the [redacted] door was open. The CNA went on to say that [redacted] knew [redacted] should have responded when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315248	A. BUILDING _____ B. WING _____	C 01/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANDOVER SUBACUTE AND REHAB II	99 MULFORD ROAD ANDOVER, NJ 07821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 11	F 689		

the door alarmed, however, [redacted] stated that they were only two CNAs working that day of the incident and could not leave the other resident in the bathroom alone. CNA #1 also revealed that LPN #1 told[redacted] too heard the door alarm sounded, however, neither of them responded nor they do a head count to check for any missing residents in the unit. Furthermore, CNA #1 stated that after the incident,[redacted] received an in-service on Wander guard/Elopement policy and responding to door alarms.

A review of the [redacted] medical records for Resident #1 dated[redacted] at 7:34 a.m., the Emergency Room (ER) physician documented the following:
History of Present Illness: Resident #1 was found sitting outside at 4:45 a.m. in -4 (negative 4) degree Fahrenheit weather without shoes or proper outwear. The Resident was transferred to [redacted].
Physical Exam: [redacted]
Emergency Course and [redacted]
The ER physician further documented that the Resident's family agreed for admission with diagnoses o[redacted].

Resident #1's medical record from the [redacted] documented by the admitting Physician

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315248	A. BUILDING _____ B. WING _____	C 01/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANDOVER SUBACUTE AND REHAB II	**99 MULFORD ROAD ANDOVER, NJ 07821**

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F 689	Continued From page 12 on [redacted] at 10:09 a.m., showed during physical examination the Resident's [redacted] The Resident was reassessed at 3:00 p.m., and the [redacted]. The admitting Physician further documented under Assessment/Plan the following but was not limited to: [redacted] The Advance Practical Nurse (APN) for the [redacted] documented on [redacted] at 4:31 p.m., revealed that [redacted]. The Resident was at [redacted] Further review, documented by the [redacted] physician on [redacted] at 6:58 p.m., showed under "Physical Exam" the Resident had [redacted] Furthermore, the [redacted] documented on [redacted] at 8:57 a.m., under [redacted], showed .. [redacted]	F 689		

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	315248	A. BUILDING _____ B. WING _____	C 01/30/2019

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F 689	Continued From page 13	F 689		

[redacted]

The "LICENSED PRACTICAL NURSE" job description, was revised on 6/2012, showed "PRIMARY FUNCTIONS:
1. Carries out physicians' orders in accordance with limitations imposed by the Nurse Practice Act in the State of NJ [New Jersey].
2. Implements physicians' orders timely and accurately. Documents accurately and completely ...
5. Organizes and directs nursing functions of residents on the unit ..."

The policy titled "WANDER GUARD - CARE OF THE PATIENT WITH" was revised on 1/29/19, showed: " ...To secure the safety of wandering residents and thereby reinforce the policy against elopement ...Procedure: ...2. The 11-7 QA aide or designated other will obtain current list once a week and locate residents using the Wander Guard Security Units. 3...e. The 11-7 QA aide or designated other will check all units once a week. 4. Document Wander Guard safety check on the current resident list by signing initials next to the resident's name, on the date the check is done ..."

The policy on "ELOPEMENT PREVENTION POLICY" revised on 1/29/19 showed; "It is the policy of the [Facility] to institute measures to ensure the safety of all residents and to prevent elopement...The same policy under "HOW TO PREVENT ELOPEMENT" showed "Elopement constitutes a violation of Federal and State

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F 689	Continued From page 14	F 689		

statues which provides for twenty-four (24) hour protective oversight. An incident could be regarded as negligence on the part of the facility ...MEANS TO DECREASE CHANCE OF ELOPEMENT ...B. TECHNOLOGY:1. Wander guards. 2. Alarmed exits with codes or alarms. 3. Prompt response by staff with activation ...REMINDERS ...2. Never ignore or reactivate an alarm ..."

The policy on "DOOR ALARMS" created on 1/22/19 (after the incident), showed "It is the policy of this facility to have an alarm on all exit doors that are accessible to residents." The same policy under the "PROCEDURE" showed "1. Upon hearing the door alarm, all staff will respond to the alarm. The staff members will visually check the door...3. If there is no obvious reason for the activation of the door alarm, an immediate head count will be started on all residents in the unit that the alarm sounded ..."

The IJ was identified on 1/29/19 at 2:44 p.m., for 1/21/19, involving Resident #1. The immediacy was removed on 1/29/19, when the facility submitted an acceptable Plan of Correction (POC) which included but was not limited to: LPN #1 was educated to respond to door alarms, policy on Wander Guard (electronic device that monitors resident movement and alerts staff) Placement and Elopement, security guards were stationed on the exit doors on the [redacted], and loading dock door until a new code was established on 2/1/19, by the alarm company.

The facility provided an acceptable POC on 1/31/19 that the showed the following:

1. Resident affected by the deficient practice:

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F 689	Continued From page 15 On January 21, 2019 at approximately 4:45 A.M., Resident was found by the HS outside sitting on the sidewalk by the laundry loading dock. The supervisor then ran into the building to get assistance and immediately notified staff who consequently ran outside to bring the resident in. Resident was brought into the building and provided medical attention. 911 was called and resident was taken to [redacted]. Physician and family were notified. The LPN (nurse) was educated on the Facility policy and procedure on Door Alarm / Wander Guard placement on January 29, 2019. In addition, the LPN was reeducated on reviewing doctor's orders and signing that interventions were in place. Furthermore, [redacted] was re-educated on the Elopement Policy. 2. Identify other residents who could be affected by the deficient practice: All residents on the unit could be affected by this deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficiency would not recur: a. Door Alarm/Wander Guard Policy was reviewed and updated by members of the QAPI team on January 22, 2019. b. Staff in-service on updates to Door Alarm/Wander Guard Policy as well as Elopement Policy was initiated on January 22, 2019 and is ongoing.	F 689		

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F 689	Continued From page 16	F 689		

c. Each week the 11-7 QA shall test Wander Guards' alarm for proper functioning.

d. Security guards were stationed at the [redacted] door, Center Core Lobby door, and loading dock backdoor, starting on January 28, 2019 until a new code was established.

e. The door alarm repairman changed the code on the loading dock backdoor on January 29, 2019.

f. On January 31, 2019 certain designated Maintenance staff and the Administrator were in-serviced not to give out the secret code to the loading dock door.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:

a. Door Alarm/Wander Guard Policy as well as Elopement Policy will be discussed in general orientation, as well as annually discussed to all employees during the monthly resident safety in-service.

b. Maintenance will check daily three times (at 8 A.M., 5 P.M., and 9 P.M.) all doors with an alarm to see that they are working properly, and will log that these doors have been inspected, indicating any findings on such checks.

i. These logs will be given to Administration, and any finding of defect or disrepair will be corrected immediately.

ii. Additionally, these logs will be filed in a

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F 689	Continued From page 17 Maintenance log book entitled, "Maintenance Door Check," and will be kept in the Administration Office. c. This documentation for completion of Wander Guard function check will be monitored for compliance and signed off by Assistant Director of Nursing or designee. d. An elopement drill will be done this quarter on each shift, and bi-annually for further drills. The results of these drills will be reviewed during the facility's Quality Assurance Performance Improvement meetings. Any issues identified, will be immediately corrected. Additional training will be provided if applicable. Completion date: 1/31/19. NJAC 8:39-27.1(a)	F 689		